

<b>Case Number:</b>	CM15-0053380		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	03/15/2006
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Internal Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 66 year old male, who sustained a work/ industrial injury on 3/15/06. He has reported initial symptoms of low back pain. The injured worker was diagnosed as having post lumbar laminectomy syndrome, low back pain, spinal/lumbar Degenerative Disc Disease (DDD), muscle spasm, mood disorder, disc disorder, and lumbar radiculopathy. Treatments to date included medication, surgery (prior two level transforaminal lumbar interbody fusion on 2/21/08), epidural injections, orthopedic consult, and diagnostics. Magnetic Resonance Imaging (MRI) was performed on 1/19/09 and 5/28/10. Computed Tomography (CT) was performed on 8/20/11. Currently, the injured worker complains of low back pain with numbness and tingling in bilateral lower extremities. The treating physician's report (PR-2) from 2/2/15 indicated the pain level had increased from last visit with rating 8/10, quality of sleep is poor, and activity level has decreased. Examination revealed restricted range of motion. Paravertebral muscles, spasm, tenderness and tight muscle band is noted on both the sides. Straight leg raise (SLR) is positive. Motor strength is 4-/5 and light touch sensation is decreased over the lateral calf on the right side. Treatment plan included physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**PHYSICAL THERAPY 2XWK X 6 WKS LUMBAR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment. ODG Preface, Physical Therapy Guidelines. ODG - Low Back - Lumbar & Thoracic (Acute & Chronic) Physical therapy (PT).

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Official Disability Guidelines (ODG) present physical therapy PT guidelines. Patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) recommends 10 physical therapy for lumbar sprains and strains and intervertebral disc disorders. Medical records document a history of discogenic disc disease with posterior two-level fusion at L4 to S1 with instrumentation on 02-21-2008. Physical therapy two times a week for six weeks for lumbar was requested. The primary treating physician's progress report dated 02-02-2015 documented subjective complaints of pain. No new problems were noted. Diagnoses included post lumbar laminectomy syndrome, low back pain, lumbar spinal degenerative disc disease, and lumbar disc disorder. No functional improvement with past physical therapy for the lumbar back were documented. In the past, the patient had been authorized for 18 physical therapy sessions. Per ODG, patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. The request for 12 visits of physical therapy for the lumbar exceeds MTUS guidelines, and is not supported. Therefore, the request for physical therapy two times a week for six weeks (12) for lumbar is not medically necessary.